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**Jan Ilhan Kizilhan***

Head, Department of Mental Health and Addiction, Dean, Institute of Psychotherapy and Psychotraumatology, University of Duhok/Iraq, Baden-Wuerttemberg Cooperative State University, Schrambergerstr. 26, 8054 Villingen-Schwenningen, Germany

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***Corresponding author:** Jan Ilhan Kizilhan, Professor, Head, Department of Mental Health and Addiction, Dean, Institute of Psychotherapy and Psychotraumatology, University of Duhok/Iraq, Baden-Wuerttemberg Cooperative State University, Schrambergerstr. 26, 78054 Villingen-Schwenningen, Germany, Tel: ++49 (0)77203906217; E-mail: kizilhan@dhbw-vs.de

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Research Article

# Forced Marriage and Mental Health by migrants in Germany

## Abstract

**Background and Objectives:** The study examines the extent to which a link exists between forced marriage and the frequency of mental illness.

**Methods:** Female migrants both in forced marriages and not in forced marriages with a Turkish background were compared in psychosomatic clinics in Germany with regard to their psychological complaints.

**Results:** Turkish women in forced marriages suffer from mental health problems with significantly greater frequency and, on average, have attempted suicide at least four times.

**Conclusion:** They suffer the consequences of a forced marriage for their entire lives, and they require special psychosocial counselling and both medical and therapeutic treatment which takes specific cultural and migration aspects into consideration.

## Introduction

Problems associated with forced marriage have been the subject of discussion at a political level and in the media in European countries for some years now. For instance, legislation has been passed against forced marriage in Switzerland and Germany and, simultaneously, numerous projects have been initiated which, fundamentally speaking, aim to protect people against being forced into marriage and the support and care of those individuals affected [1,2]. Despite this, the research conducted contains very little reliable data on the frequency of forced marriage and its medical and psychosocial consequences [3].

Based on the level at which counselling is accessed, it is only possible to guess at the number of people who are in reality affected by forced marriage [4]. For example, the Free State of Bavaria reported in 2012 that, based on a general survey of counselling services and refuge shelters conducted in 2008, a total of 228 individuals were being cared for in relation to the issue of forced marriage. 16 % of these were minors. 44 % were individuals between the ages of 18 and 21, representing the majority in these cases. Up to the age of 21, the majority of those seeking advice were not yet married [5].

Forced marriage is primarily discussed in Europe with regard to people with a migrant background and, in Germany, in particular with regard to those of Turkish origin. This chiefly occurs in the context of the debate on migration and integration, coupled with domestic violence – particularly violence against women in this respect – and in relation to human rights violations [1,6].

A forced marriage is defined as a marriage coerced through violence or threats from at least one person. It generally takes place with the consent of the parents who, among other things, also assume the role of perpetrators to a certain degree and, for example, force their own daughter or son to marry. It is not governed by any particular religious persuasions. In patriarchal cultures, such marriages are regarded as benefitting the collective, be this the family or tribe [7]. Male individuals are also affected. Marriage here is regarded as having a functional and less emotional value, as it should serve the protection (e.g. marriage into a powerful tribe) and survival (e.g. procreation) of the collective [8,9].

In contrast to forced marriage, so-called arranged marriages exist in these cultures which, for example, are initiated by relatives and friends or acquaintances – with the consent of the couple to be married. If, however, the individuals to be married have, from a cultural point of view, learned not to contradict their parents or friends and acquaintances in this regard and accept this marriage in silence, this can also be considered a forced marriage to a certain degree [10]. In extreme cases, and in combination with the biography and system of values of these societies, young women who resist a marriage of this



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kind may find themselves subject to considerable mental and physical pressure [11]. In some cases, they suffer death at the hands of their immediate family members, a practise known as so-called "honour killings" [3].

Due to international economic globalisation, the expansion of travel opportunities, networking through other media, industrialisation, ethnic and religious conflicts, environmental changes, natural catastrophes and epidemics, an increase in migration has been observed over recent decades in many countries around the world. People migrate for a variety of reasons. However, their cultural backgrounds in terms of family and religion, their individual biographies and their migration histories may make it difficult for them to address the issue of forced marriage, both in public and in institutions [12].

No study has been conducted to date of migrants in forced marriages in Germany and the possible mental illnesses associated with this, and it is for this reason that we have examined whether a relationship exists between forced marriage and mental illnesses and if this group differs from other migrants who have also undergone inpatient treatment in psychosomatic clinics in Germany for psychological complaints.

## Method

A comparison was made of female migrants who stated that they were forced into marriage in their country of origin and, as a consequence, suffered considerable stress, both in the marriage itself and their social environment. The frequency with which mental illness is encountered and their manner of dealing with this would provide indications for diagnostic and treatment strategies.

Female patients with a Turkish background were examined in three psychosomatic clinics in Bavaria and Baden-Württemberg who were undergoing inpatient treatment for at least one psychological complaint – primarily involving various forms of depression, anxiety and somatization disorders. These examinations were conducted in the mother tongue in each case in individual and group therapy, creative therapy and psychoeducative seminars.

Diagnoses on discharge were consulted for evaluation, as these were based on standardised diagnostics employed by the clinics. In addition to initial diagnoses, all other diagnoses were also taken into consideration.

### Random sampling

We investigated patients with migrations background in three psychosomatic hospitals in Bavaria and Baden-Württemberg. In all three hospitals they were treated using single and group therapy sessions in conjunction with psycho-educative seminars in the mother tongue and cultural background. Those psychosomatic clinics are specialized for a treatment of patients with migrations background.

Data was collected in the context of a *comparative study conducted over ten years of the psychosomatic rehabilitation of women inpatients with a migrant background (orgin Turks, Kurds and Arabs)*, and the evaluation addressed the interaction of psychological disorders and forced marriage in particular.

Sociodemographic data was gathered through the posing of questions relating to family, marriage, forced marriage and arranged marriage.

In order to compile a "Forced marriage" group, female patients were drawn upon who, according to the details they had provided, had already been married against their will in their country of origin. They had all been born and grown up in their country of origin and had, on average, lived in Germany for longer than ten years. Individuals in the "Non-forced marriage" group were female patients who had also been born and grown up in their country of origin and, on average, had been living for 15 years in Germany. These patients stated that they had married of their own free will.

Female patients who had experienced war and/or been traumatised, experienced other extreme forms of stress and the status of whose residence permit was unclear were excluded from the investigation, as were female patients who had entered a forced marriage before reaching the age of 18, because psychological development and traumatic aspects could have played a role in these cases and led to a distortion of the data collected.

The female patients who admitted to having been forced into marriage had not previously approached a counselling service or other institution in relation to this issue. Due to the expected differences between the two groups with respect to gender, age, level of education and diagnosis, the two samples were parallelised in order to ensure comparability and to enhance the inner validity of the study.

For this reason, female patients under 30 and over 55 years of age who were to be found more frequently in the "Non-forced marriage" group were excluded. In addition, consideration was not given to any female patients who were illiterate, had a university qualification or, during the year of the investigation, had already undergone treatment in a psychosomatic clinic.

In total, 142 female patients in the "Forced marriage" group and 172 in the "Non-forced marriage" group took part in the survey. These were finally reduced to 120 female patients in the "Forced marriage" group and 150 in the "Non-forced marriage" group, due to the absence of data and a questionnaire not being filled out with the required accuracy.

### Survey instruments

*The Koch sociodemographic questionnaire (1997)* had already been employed in various studies [13] and provides important background information on the person (place of origin, religion, migration, family, occupation, financial situation, duration of illness, treatment, etc.). Data on religious affiliation and practice was gathered through special questions on "Religion and faith" integrated as an independent category in this questionnaire.



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The extent of depressive symptoms was recorded with the *Beck Depression Inventory* [14] and its Turkish version [15, 16]. Validation of the questionnaire indicated a high degree of internal consistency in the Turkish version, with values around 0.85 being recorded. Numerous validation studies are available for these which assume a high level of valid and reliable recording of depression among patients with a Turkish background [17]. Cut-off values of 11 and 18 also apply in the Turkish version.

The *Symptom Checklist (SCL-90-R)* [18] measures the subjective experiencing of impairments in an individual due to physical and mental symptoms within a period of seven days. The Turkish version of SCL-90-R (the checklist) was examined by Dag (1991) with regard to its reliability and validity [19].

### Evaluation

The data collected was computed with the SPSS 15.0.1 program for Windows (2006), while graphs and tables were compiled in SPSS 15.0.1 and Excel 2003 from Microsoft Office. Descriptive data was illustrated as mean values of the standard deviation, and categorical parameters as percentages.

The comparison of both investigation groups with regard to symptoms of illness was calculated with $\chi^2$-tests, t-tests and a univariate two-factor analysis of variance. The relationships between SCL-90-R and BDI were calculated separately on the basis of bivariate Pearson's correlations for both groups.

### Description of random sampling

The average age of the "Forced marriage" group was 42.9, while that of the "Non-forced marriage" group was 46.7 years of age. Female patients in the "Forced marriage" group exhibited a significantly lower level of education ($\chi^2$=37.00, p<.001), a lower general level of gainful employment ($\chi^2$=3,634, p<.044) and had a lower income than the "Non-forced marriage" group. These had more children ($\chi^2$=10.634, p<.003), the average being 3.9. The mean value for the "Forced marriage" group was only 2.6.

## Results

### Clinical psychological patterns

In the case of the diagnosis of "Depression", patients in the "Forced marriage" group were represented with significantly greater frequency than the "Non-forced marriage" group (-Chi²= 9,42, p<.001). The same applies to the diagnosis of "Personality disorders" (Chi²= 4.374, p<.001) and "Eating disorders" (Chi²= 8.162, p<001). Significant differences were also apparent in relation to somatoform disorders, with patients in the "Forced marriage" group at 42.1 % being represented with significantly greater frequency when compared to 29.2 % of the "Non-forced marriage" group (-Chi²= 9.88, p<.034). Diagnoses in the schizophrenic circle tend to be higher for the "Non-forced marriage" group than those in the "Forced marriage" group (Figure 1).

### Symptomatology

Table 1 illustrates the mean value difference in depression (BDI) and psychological symptomatology (SCL-90-R). All nine subscales of the SCL-90-R and the Global Severity Index (GSI) indicated significantly higher values (p<.001), including for depression (BDI value of 35.2 points), for the "Forced marriage" group when compared to the "Non-forced marriage" group (BDI value of 22.5 points). With a t-value of -3.431, this difference was highly significant (p<.001).

### Suicidal tendencies

In contrast to the "Non-forced marriage" group, the "Forced marriage" group reported at least four suicide

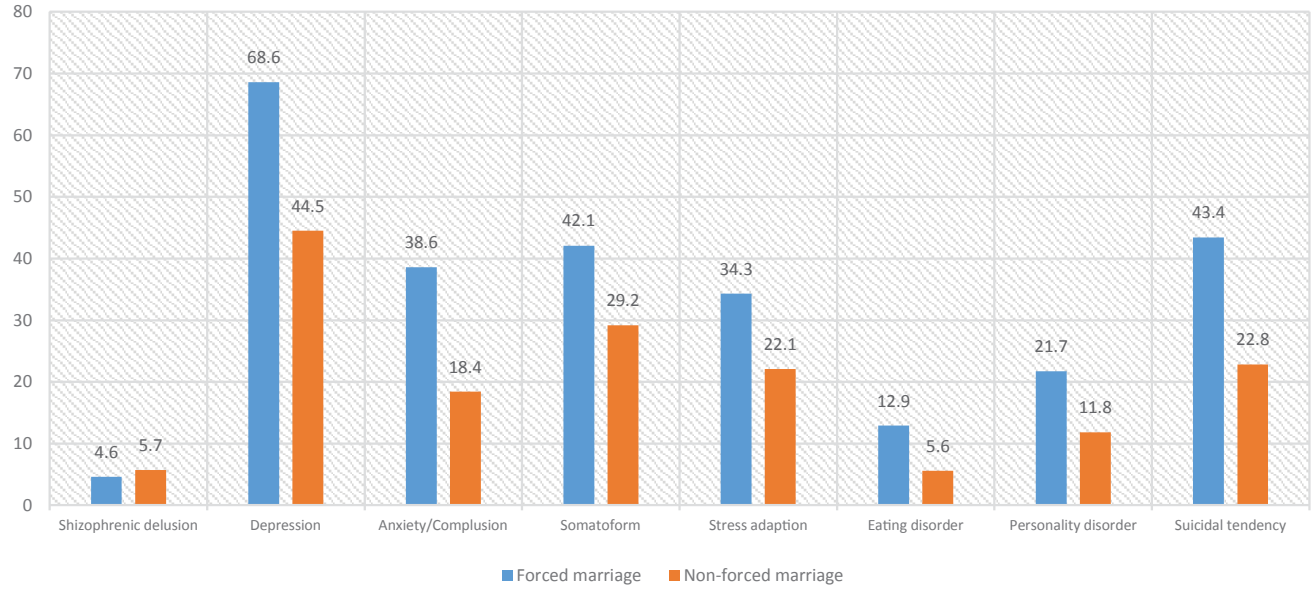


**Figure 1:** Diagnoses of the *Forced marriage* and *Non-forced marriage* groups.



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**Table 1:** Mean value comparison (t-tests) of both groups with regard to depression (BDI) and symptomatology (SCL-90-R).

| Variable | Group Forced marriage (N=120) | | Group Non-forced marriage (N=172) | | Overall sample (N=292) | |
|---|---|---|---|---|---|---|
| | MW | SD | MW | SD | t | p< |
| BDI | 35,20 | 11,21 | 22,51 | 11,27 | -3,431 | .001 |
| SCL-90-R | | | | | | |
| Somatisation | 73.40 | 7.11 | 63.19 | 13.72 | -3.385 | .001 |
| Compulsiveness | 74.10 | 4.52 | 63.63 | 11.68 | -4.514 | .001 |
| Uncertainty in social contact | 72.02 | 9.64 | 60.28 | 12.32 | -3.112 | .001 |
| Depression | 74.32 | 5.52 | 64.78 | 11.77 | -4.289 | .001 |
| Anxiety | 73.23 | 8.55 | 62.19 | 10.55 | -4.029 | .001 |
| Aggression/ Hostility | 69.83 | 11.22 | 56.81 | 10.35 | -4.089 | .001 |
| Phobic anxiety | 71.97 | 9.97 | 60.02 | 11.62 | -4.894 | .001 |
| Paranoid ideation | 69.78 | 10.12 | 57.48 | 11.54 | -4.518 | .001 |
| Psychoticism | 73.90 | 7.06 | 60.64 | 10.84 | -5.903 | .001 |
| GSI (Global Symptom Index) | 77.76 | 6.93 | 55.72 | 11.10 | -4.435 | .001 |
| Suicidal tendencies | 4.03 | 1.48 | 0.98 | 0.79 | -6.171 | .001 |

attempts since the forced marriage. With a t-value of -6.171, this difference was highly significant (p<.001). In addition to the forced marriage, reasons for suicidal tendencies given included abuse by the husband and his family (72.1 %), violence (67.4 %), low to zero support from parents and siblings (52.8 %) and rape (31.4 %).

### Duration and severity of stress

Moreover, it was determined that the "Forced marriage" group had been complaining on average for 13.2 years and the "Non-forced marriage" group for 6.3 years about their difficulties. The most frequent remedies taken were antidepressants ("Forced marriage" group: 98 %, "Non-forced marriage" group: 97 %) and analgesics ("Forced marriage" group: 91.4 %, "Non-forced marriage" group: 75 %). The female patients had consulted at least three medical specialists in the areas of orthopaedics, gynaecology or internal medicine since their complaints began, and their family practitioner several times a year.

The patients reported most frequently on psychosocial stress in the marriage ("Forced marriage" group: 84.3 %, "Non-forced marriage" group: 52.7 %), with children ("Forced marriage" group: 58.1 %, "Non-forced marriage" group: 36.7 %) and in the workplace ("Forced marriage" group: 61.9 %, "Non-forced marriage" group: 60,4 %). 89.2 % of the women in the "Forced marriage" group and 49.3 % in the "Non-forced marriage" group were unskilled workers.

In the case of over two thirds (71.8 %) of the "Forced marriage" group and 43.6 % of the "Non-forced marriage" group, the need for outpatient psychotherapy had been considered urgent.

## Discussion

This study involved the examination of female patients in psychosomatic clinics both in forced marriages and not in forced marriages with regard to their psychological complaints.

Female patients in forced marriages had a lower level of education and weaker knowledge of the German language than the "Non-forced marriage" group. They reported psychosocial stress (marriage, children, and work) with considerably greater frequency than the "Non-forced marriage" group.

Both groups suffered in the main from depression, somatoform illnesses and anxiety disorders, whereby the "Forced marriage" group exhibited these illnesses with significantly greater frequency. The "Forced marriage" group had on average exhibited the symptoms described for 13 years, while the "Non-forced marriage" group had complained of these problems for six years.

The "Forced marriage" group reported frequent suicide attempts in the past, with female patients in this group having on average attempted suicide at least four times, chiefly through the use of medication. No studies existed prior to this on the interaction between forced marriage and psychological illnesses. Studies of men in forced marriages and their possible ailments were also unavailable. From personal clinical experience, the author is aware that men have also been coerced into forced marriages, although fewer of these individuals are encountered in terms of frequency when compared to women. They also reported numerous examples of stress and conflict in the marriage. However, these reports contained, among other aspects, no examples of violence being experienced, whereas violence occurred very frequently in the case of women.

Quantitative studies on individuals in forced marriages who sought out counselling services or women's shelters reported high levels of psychosocial stress such as anxiety, insecurity, the experiencing of violence and exclusion which, with a high degree of probability, also led to psychological illnesses in the case of many of the people affected.

The study conducted by Strobl & Lobermeier (2007) reported that those affected only obtained help from a very few friends and acquaintances, individual parents, employees of youth welfare offices, social workers of both sexes in advice and youth centres, individual case and family aid workers, both male and female, male and female work colleagues, lawyers and, in the case of underage school pupils, teachers of both sexes [20]. Psychological or psychiatric support was seldom obtained.

Whether those affected find these types of support or not depends heavily on their social networks. In the majority of cases, friends of both sexes are the individuals responsible for trying to bring them to counselling centres or even the police through their network. Psychotherapeutic treatment is secondary in the separation and help-seeking phase, as many are initially concerned about their personal safety and security.

Our study indicated that the majority of women had already married in Turkey, then came to Germany and possessed little information on the system of assistance and support options available in the country. Many women regarded a separation as problematic from a cultural and religious point of view and had submitted to their fate [21].



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A medical and psychiatric examination at an early stage and, consequently, treatment appear to be necessary to avoid a chronification, along with the examination in psychotherapy of new options for shaping a life. Sensitization on the part of family practitioners and others involved in treatment is necessary in this respect, as these can frequently be the first people sought out for help by those affected. The development of guidelines for family practitioners, gynaecologists, orthopaedists, psychiatrists, psychotherapists and other professions for the early identification of cases where those affected are subjected to violence and assessment of the level of risk could be very helpful in the context of effective prevention.

The findings of this study are significant for the treatment of female patients in forced marriages, as it proved possible to show that their ailments became apparent from the beginning of their forced marriage and subsequently intensified.

From a psychotherapeutic point of view, the motivation and goal of therapy should be reconsidered for long-term treatment. A combination of inpatient and outpatient treatment and specific social educational support would be necessary in this respect. Long-term medical and therapeutic treatment for this group should always be considered from the point of view of those bearing the costs and with a view to the desired healing success.

The available data and our psychotherapeutic experience with this group of patients indicate that specific cultural aspects [22-24] should be taken into consideration during therapy. We have compiled these in box 1.

## Conclusion

People who have been coerced into a forced marriage suffer for their entire lives as a consequence of this event and are reminded of this every day through, among other things, the nature of their spouse and social environment, these being factors which lead to extreme stress. The manner in which these people deal with their problems and integration can be radically improved if linguistic, cultural and migration-specific aspects are integrated in the counselling, treatment and social support of these individuals. Therefore, specific cultural knowledge is, in general, necessary during the treatment of individuals with a migration background and on the part of those treating them and health institutions to enable the timely and adequate treatment of these female patients and, for example, avoid a chronification of the illness. In addition to multicultural treatment teams, a sensitization of all personnel is a primary necessity in achieving a transcultural, culture-sensitive perspective.

### Consequences for clinics and practices

Cultural sensitivity and the qualification of family practitioners, gynaecologists, orthopaedists, psychiatrists, psychotherapists and other profession can reduce the inhibition threshold of those affected when it comes to seeking help and support.

During treatment and counselling, efforts should be made to provide appropriate clarification which takes the cultural

**Box 1:** Consideration of specific cultural aspects during therapy

**Consideration of specific cultural aspects during therapy**

**a) Medical and psychotherapeutic aspects**

During initial contact, ailments reported by female patients can be limited to physical pains and characterised by a fixation on these. The existance of possible psychological conflicts and stress such as forced marriage can be initially rejected or denied. Limited knowledge of the German language can complicate the anamnesis.

The feeling of not been taken seriously enough with regard to ailments can even strengthen the fixation on these (e.g. multiple, recurrent, fluctuating physical symptoms experienced on changing bodily organs). Abdominal pains are not only encountered frequently among children, but also afflict adults.

A comorbidity with other psychosocial ailments is frequently encountered. Many female patients fail to identify a possible correlation between disorders, or have up until now not been adequately informed about these.

Psychoeducative measures and information on sexual abuse, violence, honour, forms of marriage, culture, integration, prevention and intervention should be adapted to the culture of origin of female patients and made available to them.

Family members should support the female patient, insofar as these are actually willing to, and be involved in treatment and counselling with regard to resources, family dynamics, etc.

Treatment through medication, operations or physiotherapy measures can, from the point of view of the male/female client or the parents, be initially adequate.

**b) Social aspects**

- Linguistic problems (language barriers, the use of male/female interpreters and payment by health insurance providers).
- Adequate knowledge of differences of a cultural nature (the role of family members or conflict solution options in collective societies, honour, forced marriage, etc.).
- Improvement of psychological problems specifically related to migration (generation conflicts, integration etc.).
- Improved rights and protection for affected women.

**c) General provision structures**

- Timely initial identification of vulnerable female patients.
- Adequate sensitization and qualification of family practitioners, gynaecologists, orthopaedists, psychiatrists, psychotherapists and other psychosocial professions.
- The offering of a basic range of psychosocial services (counselling, low-threshold service offer) for women in forced marriages, but also for victims of sexual and domestic violence.
- The provision of psychotherapy and counselling services by persons with special knowledge and skills.
- Treatment professionals and counsellors of both sexes trained in the mother tongue who undertake diagnostics suited to the specific culture.
- Psychiatric and psychosomatic clinics with adequate transcultural competence.
- Transcultural opening of outpatient, complementary and inpatient facilities.



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background of those affected into consideration and adequate communication options (use of interpreters where necessary).

Psychiatric and psychotherapeutic treatment should take the family, cultural and religious background of those affected into consideration, along with the possible risks they face in making a decision.

## References


1. Mirbach T (2011) Zwangsverheiratung in Deutschland– Anzahl und Analyse von Beratungsfällen. Federal Ministry of Family Affairs, Senior Citizens, Women and Youth. Berlin: In-house publication; 2011.

2. Femmes TD (2011) Im Namen der Ehre. Misshandelt, zwangsverheiratet, ermordet. Hilfsleitfaden für die Arbeit mit von Zwangsheirat / Gewalt im Namen der Ehre bedrohten oder betroffenen Mädchen und Frauen. 2nd revised edition. Berlin: Terre Des Femmes; 2011. Link: https://goo.gl/brFTdp

3. Kizilhan J (2011) Überzeugungen bei sogenannten Ehrenmördern -Eine vergleichende Studie zwischen den sogenannten Ehrenmördern und anderen Straftätern mit aggressiven Handlungen. Journal: Recht und Psychiatrie 29: 88-94.

4. Mirbach T, Müller S, Triebl K (2008) Ergebnisse einer Befragung zu dem Thema Zwangsheirat in Hamburg. Hamburg: Johann Daniel Lawaetz Foundation.

5. Triebl K (2012) Zwangsverheiratung –Situation in Bayern, Landesspezifische Datenauswertung der Studie, "Zwangsverheiratung in Deutschland – Anzahl und Analyse von Beratungsfällen". Munich: Bavarian State Ministry of Employment and Social Order, the Family and Women.

6. Rude-Antoine E (2005) Forced Marriages in Council of Europe Member States. A Comparative Study of Legislation and Political Initiatives, Council of Europe. Strasbourg: Directorate General of Human Rights.

7. Kizilhan J (2006) "Ehrenmorde" – Der unmögliche Versuch einer Erklärung. Berlin: Regener.

8. İlkkaracan P (2000) Exploring the Context of Women's Sexuality in Eastern Turkey, In: İlkkaracan, P, Women for Women's Human Rights, publ. Women and Sexuality in Muslim Societies. Istanbul: WWHR 229–244. Link: https://goo.gl/3Wfju5

9. Toprak A (2007) Das schwache Geschlecht – die türkischen Männer. Zwangsheirat, häusliche Gewalt, Doppelmoral der Ehre, 2nd edition. Freiburg: Published by Lambertus Verlag. Link: https://goo.gl/2Ynm2D

10. Fish J (2010) Arranged Marriages. Billions of people live in arranged marriages. Why? The Cultural Mirror 4: 27-36.

11. Groß AV (2008) Traditionsbedingte Gewalt an Frauen im Nahen und Mittleren Osten. Tübingen: Terre Des Femmes. Link: https://goo.gl/oEufDx

12. Chantler K, Gangoli G, Hester M (2009) Forced Marriage in the UK: Religious, cultural, economic or state violence? Critical Social Policy 29: 587–612. Link: https://goo.gl/ieH6P1

13. Koch E (1997) Anamneseleitfaden für türkische Patienten am Psychiatrischen Krankenhaus Marburg. Personal communication.

14. Beck AT, Ward CH, Mendelson M, Mock J, Erbaugh J (1961) An inventory for measuring depression. Archives of General Psychiatry 4: 561-571. Link: https://goo.gl/oq8uAN

15. Hisli N (1988) Beck Depresyon Envanteri'nin geçerliği üzerine bir çalışma. Psikoloji Dergisi 6: 118-122. Link: https://goo.gl/eHrJy8

16. Hisli N (1989) Beck Depresyon Envanteri'nin üniversite öğrencileri için geçerliği ve güvenilirliği. Türk Psikoloji Dergisi 6: 3-13. Link: https://goo.gl/qR3pBg

17. Aktürk Z, Dagdeviren N, Türe M, Tuglu C (2005) The reliability and validity analysis of the Turkish version of Beck Depression Inventory for primary care. Türk Aile Hekim Dergisi 9: 117-122. Link: https://goo.gl/gVCix8

18. Derogatis LR (1977) SCL-90-R. Administration, scoring & procedures manual-I for the R(evised) version. Baltimore: John Hopkins University School of Medicine.

19. Dag I (1991) Reliability and validity of the Symptom Checklist (SCL-90-R) for university students. Tuerk Psikiyatri Dergisi 2: 5-12.

20. Strobl R, Lobermeier O (2007) Zwangsverheiratung: Risikofaktoren und Ansatzpunkte zur Intervention. Berlin: Federal Ministry of Family Affairs, Senior Citizens, Women and Youth. Link: https://goo.gl/EfwvZH

21. Schröttle M, Müller U (2004) Lebenssituation, Sicherheit und Gesundheit von Frauen in Deutschland. Eine repräsentative Untersuchung zu Gewalt gegen Frauen in Deutschland. Berlin: Federal Ministry of Family Affairs, Senior Citizens, Women and Youth.

22. Heine P, Assion HJ (2005) Traditionelle Medizin in islamischen Kulturen. In: J. Assion Hrsg. Migration und seelische Gesundheit. Heidelberg: Springer 29-45. Link: https://goo.gl/qsfiDo

23. Haasen C, Blätter A, Yagdiran O, Reimer J (2006) Subjektive Krankheitsursachen bei Patienten mit einer psychotischen Erkrankung. Ein Vergleich zwischen türkischen und deutschen Patienten. Journal: Psychiatrische Praxis 33: 30-33. Link: https://goo.gl/NsuKWF

24. Franz M, Ljic C, Koch E, Wüsten B, Yürük N, (2007) Subjektive Krankheitskonzepte türkischer Migranten mit psychischen Störungen – Besonderheiten im Vergleich zu deutschen Patienten. Journal: Psychiatrische Praxis 34: 32-38. Link: https://goo.gl/zp6Xpu






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